A Hard Look at the Future of Family Practice

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■ *The progressive fall in the status and numbers of general practitioners has produced a dangerous void in the field of comprehensive medical care. The Millis Commission and other national study committees have recommended that family practice be made a board-certified specialty in order to restore the status and numbers of family physicians. The scope of family practice that is envisioned, however, would be so restricted in depth as to raise serious doubts that sufficient medical graduates would be attracted to careers in this new specialty. Better training in broadly-based general or family practice—rather than a specialty board, per se—is the only realistic way to elevate status and attract more medical students to this field.*

Editor's Note: This article on a highly controversial, rapidly changing subject is said to express the viewpoint of the California Academy of General Practice and the large majority of general practitioners in California.

THE CONCEPT OF COMPREHENSIVE medical care, which until now has been known as general practice, is undergoing close study and analysis against the backdrop of socio-economic and technological changes affecting all of medicine. Recent trends and events associated with these studies would indicate that general practice, in its traditionally broadest application, is destined for radical revision under an emerging, altered concept of comprehensive patient care. In fact, the very words that have for many decades identified this kind of over-all care under one physician are about to fall into disuse. Such terms as *first contact physician, primary physician, personal physician,* and *family physician* are now heard instead of *general practitioner.* Of these terms, *family physician* is the one now most widely used. At its 1966 national meeting, the American Academy of General Practice adopted a resolution recommending a change in name to The American Academy of Family Physicians. In the recent past, many have proclaimed the imminent demise of the general practitioner, and this action by the Academy sounds the death knell of the old name at least, while ringing in the specialty of family practice.

Whether comprehensive and continuing care based on one physician is labelled family practice or general practice is of no moment. What is *meant* by family practice in the context of the emerging recommendations that envision this branch of medicine as a bona fide, rewarding and attractive specialty is a matter of real concern. For, unless family practice does possess these qualities, it cannot successfully compete with the other branches of medicine. Without them it will fail to draw medical students and graduates into its fold no matter how many board certificates or specialty diplomas may be entailed. It follows that if candidates are not attracted in sufficient numbers to this new specialty, then the new family physician will soon join the old general practitioner in extinction.

Preparations for establishing a Board of Family Practice proceed apace. These preparations are carried forward by a chorus of approbation in

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which the voice of organized medicine is heard with hardly a discernible note of dissent. The public has also joined in the general acclaim, anticipating that its long unheeded clamor for more family physicians is about to be answered. Suddenly, family practice is to become a high-ranking specialty and is to enjoy equal status in the house of medicine.

The general approval is summarized in the reports recently issued by three separate committees, namely, the Millis Commission (the Citizens' Commission on Graduate Medical Education), the American Academy of General Practice Committee on Requirements for Certification, and the American Medical Association Ad Hoc Committee on Education for Family Practice. These reports are in almost complete agreement on the basic structure projected for the new specialty of family practice. Any assessment of the future of family practice must rest on an examination and interpretation of these reports.

First, let's consider the matter of status. Admittedly, the status of the family physician has fallen as that of the specialist has risen. Medical students have understandably become less and less attracted to careers in family practice. Medicine itself, and hospitals in particular, have joined in this layering of status. Much of the public, too, began to think of the family physician as a second class citizen within the medical community. It is little wonder that medical students gave family practice a wide berth. All three of the reports cited above recognize the importance of this factor when they speak of the equal status that the family physician of the future must have.

How is this high status to be gained? By giving the family physician a board certificate? Obviously, such a certificate is but window dressing. What will the substance behind the certificate be? What will the family physician of the future do? What will he be trained to do? And, perhaps most importantly, what will he be *allowed* to do? For, status in our society is entwined with *doing*.

The three reports are in general agreement that family practice is to be a specialty in breadth rather than depth. Although it is certainly a completely new definition of "specialty," this concept would appear to carry with it an aura of special status. The epithet *breadth* seems innocuous enough at first sight. However, since all the other specialties are specialties in depth, it follows that family practice must stay superficial in all its breadth if it is to avoid encroachment and conflict *vis-a-vis* its sister specialties. Such superficial participation in medicine, no matter how broad, cannot be broadly rewarding or attractive—if, indeed, it can be called a specialty.

Let us examine the concept of breadth-rather-than-depth against its historical background. Until very recently, every attempt to assemble and launch a Board of Family Practice foundered because it was inevitably on a collision course with already established specialties, notably and most dramatically with that of surgery. However, the conflict exists no less substantially and essentially with such other specialties as obstetrics, orthopedics and internal medicine. Until recently, it was apparent to all who studied the matter that in order for family practice to be presented as a rewarding and attractive career in medicine, it must encroach to some flexible degree of depth upon the other specialties. Without this encroachment, the family physician could not offer the type of comprehensive and continuing care for which there is public clamor. With this encroachment, it appears impossible for a Board of Family Practice to gain the cooperation and approval of the established specialties. This has been the impasse faced by attempts to define an acceptable Board of Family Practice.

How has this impasse now been solved? Very simply, by skirting around it. The previously unsolvable problem has been solved by ignoring it. Briefly, the problem is that there has been an undesirable decline in the numbers and status of family physicians and that a dangerous vacuum has developed in the area of comprehensive and continuing health care. The searched-for solution has been to elevate the status of the family physician, attract a greater number of medical graduates into family practice and thereby eliminate the vacuum.

One of the committees above cited (AAGP Committee on Requirements for Certification) chides those who would persist in pursuing the "impossible" solution—that is, the solution directed toward a Board of Family Practice that would include the right to be involved in any medical discipline for which the family physician is qualified by reason of training, experience and talent. The public, and supposedly the American Academy of General Practice, have been pressing for this level and this concept of comprehensive and continuing care based on a well-trained family physician. The committee finds a "solution"

by abandoning this goal and the need that underlies the problem and then substituting something called "the family physician of the future." Thus, a solution is arrived at by changing the nature of the problem.

All three Committees and their spokesmen, either openly or by inference, envision the family physician of the future as a family counselor, an advisor on environmental medicine, a junior-grade psychiatrist, a practitioner of preventive medicine, a therapist for minor complaints and, finally, a reliable diagnostician capable of recognizing serious illness and knowing what specialist or group of specialists should be called upon for definitive action. Of course, the family physician of the future will be the "captain of the team" and the "coordinator" of the assembled talent. This will be his new and high status as a diplomate of the coming Board of Family Practice. It matters not that the full-fledged general practitioner of today is already doing this and more, yet is presumably lacking in status.

Before embarking on a three- or four-year residency in family practice, the medical graduate will want some answers and some assurances. If the board-certified family physician of the future is qualified by virtue of training and experience to diagnose and repair an inguinal hernia, will his right to perform the indicated operation be respected? If he is equipped by training and experience to diagnose and treat a coronary occlusion, will be be allowed to attend his patient without calling in unnecessary consultation? If a fracture lies within the scope of his training and experience, will the patient be allowed to receive the direct, continuing care of his family physician? These are some of the questions that a potential candidate for a family practice residency must ask. Statements ranging from "the family physician of the future should not expect to do surgery" to "he should be prepared to do 'applicable' surgery" are hardly satisfactory answers. With equal logic, the prospective resident can certainly project the restrictions in surgery to the other specialty fields of medicine. He will probably come to the conclusion that he cannot live by breadth alone and will choose to immerse himself deeply in one of the "real" specialties.

What are the alternatives? First, it would be well to get back on the track of the original problem, which is to really raise the status of the family physician so as to attract greater numbers of medical graduates to careers in family practice.

Basically, the principal factor responsible for the loss in status by the family physician has been his failure to achieve adequate training in relation to the changing medical climate of the last several decades. Approximately 75 per cent of today's general practitioners have not had *any* residency training. This is to say that the preparational background required of the general practitioner has not changed materially in the past 30 to 40 years, a time during which the rest of medicine was imposing ever higher standards of graduate education upon itself. This is the basic reason that the general practitioner has suffered a fall in status in the eyes of his colleagues and his patients—and probably, too, in his own eyes.

If we grant, in light of the needs of today and of the reasonably foreseeable future, that there does exist a critical necessity for the survival and growth of family practice, the problem is not met by destroying the concept of family practice in order to satisfy the compromises and concessions that would make possible a Board of Family Practice. If family practice is really a desirable and needed thing it will remain so, whether with a board or without. The way to elevate the status of family practice is not through a dilution and weakening of its content but through a real elevation of standards that will justify the vigorous retention of all its traditional content. Whether such elevation includes a formal board is of no intrinsic consequence.

The indicated elevation of standards in family practice must be accomplished in the same manner that it has been achieved in the specialties—through the creation of enough *good* residencies. The California Academy of General Practice, the largest state chapter of the AAGP, has pioneered such residencies on a limited scale. The experience gained and the results of these programs have been reassuring and encouraging. These high-quality residencies attract more candidates than there are posts available. They encompass a high level of training and experience in depth in the disciplines of broadly based family practice. The family physician emerging from a residency program of this type need have no misgivings about status. He possesses the credentials of adequate preparation and the capability of *doing*. These are the keys to status and to self-esteem.

Such high-quality residencies are needed in great numbers and on a national scale if we are to fill the vacuum that has arisen in family practice.

Medical schools and graduate education programs must undergo a reorientation in dominant goals and a repolarization of emphasis in favor of producing more well-trained family physicians. Some specialty fields are already over-crowded. It is probably true that if there were not now a shortage of family physicians, there would now be an oversupply of practically all specialists. Perhaps the field of the specialist should revert to what it was in the beginning—the rare, the unusual, the complicated case. Perhaps the board specialist in obstetrics and gynecology should not be interested in attending the routine pregnancy and delivery. Perhaps this should be the province of the well-trained family physician, who will recognize the rare, the unusual, the complicated, and call in the specialist consultant. An army of well trained family physicians backed up by a select corps of board specialists would appear to answer the clamor against too many generals and too few generalists.